

# **The Respecting Patient Choices (RPC) program**

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The Respecting Patient Choices Program is a comprehensive advance care planning program. It began in 2002 as a pilot project at the Austin Hospital, Melbourne, Australia and continues to be implemented across Victorian health services, the residential aged care setting, and is now established in each state and territory across Australia.

The Program was derived from the Respecting Choices® program (<http://www.respectingchoices.org>) developed by the Gundersen Lutheran Medical Foundation (GLMF) in Wisconsin, USA but is now fully developed in its own right, to ensure that the language, education materials and system changes that are promoted are applicable to the Australian health care system.

The Respecting Patient Choices Program:

- respects every person's right to autonomy, dignity and fully informed consent
- assists individuals to:
  - reflect upon their goals, values and beliefs
  - to understand their current and future medical situation and possible treatments and outcomes
  - to determine and communicate their wishes regarding their current and future health care
  - to appoint a surrogate decision maker
- educates and supports health professionals regarding advance care planning and the importance of quality end-of-life care.
  - This includes specific education of advance care planning facilitators, (see below) as well as more generic education for all health care staff
- ensures appropriate systems and policies are in place in health care organisations to support advance care planning including:
  - appropriate systems in medical records to ensure Advance Care Plans are readily available when required and that, if a surrogate is appointed, these details are readily accessible
  - adequate availability and training of advance care planning facilitators
  - policy to specifically support advance care planning, quality end-of-life care, limitation of medical treatment, and provision of palliative care

## **Training of advance care planning (ACP) facilitators**

Advance care planning facilitators are nurses and allied health staff who have completed the “Respecting Patient Choices” training. This requires the health care worker to firstly complete the e-learning program, and then to attend a one-day interactive workshop.

### **1. E-learning:**

*To complete the e-learning program (approximately 6-8 hours).*

There are six modules in the e-learning course and participants work through these modules in sequence. There are self-assessment points in each module to assist the learning. At the conclusion of each module there is a final assessment.

Module 1: What is Advance care Planning

Module 2: The role of health professionals in advance care planning

Module 3: Discussing treatment choices

Module 4: Communication strategies for Advance Care Planning Discussions

Module5: Bringing it all together: LAST STEPS

Module 6: Integration – A system wide Advance Care Planning program

### **2. One day workshop: (approximately 8 hours duration)**

*The one day workshop is very interactive and includes a number of role plays, and interactive discussions.*

PART 1: INTRODUCING THE CONCEPT...WHY DO advance care planning?

Why is advance care planning important; how does it work; what happens if it is not done; what do we want it to achieve

PART 2: HAVING THE CONVERSATION

Stage 1: Establish who to talk to if a person gets too sick to speak for themselves (Nominating a Substitute Decision Maker)

- The role of capacity in decision making
- Choosing a substitute decision maker

Stage 2: Establish what sort of medical treatments a person would or would not want at the end of their life

- Asking what a person understands about their illness.
- Establishing a person's "reasonable outcome" or what is necessary for them to "live well" and how this is informed by their goals and values in life.
- Finding out what treatments people expect if they become critically unwell
- Defining what treatments we are talking about "Life prolonging treatments" & cardiopulmonary resuscitation
- Relating the patient's "reasonable outcome" to their expectations (are aggressive interventions compatible with their idea of a reasonable outcome?)

Stage 3: Record these wishes in a form that Doctors will recognise and be able to act upon

- Documenting the discussion

### PART 3: WHAT NEXT? WHAT ELSE DO WE NEED TO MAKE ADVANCE CARE PLANNING WORK?

- Disseminating the knowledge - making sure everyone knows about the decisions made.
- System changes